Leading article

Surgical Ethics During a Pandemic: Moving into the Unknown?

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As the Covid-19 pandemic develops and demands for healthcare increase, the impact will be felt in every sector of every healthcare system, including the cancellation of elective surgery[1]. The rationale behind cancellation is compelling: it frees up both beds and staff, allowing resources to be redeployed to the front line. This seems like a simple (if incomplete) response to the problem of insufficient resources, but the apparent simplicity belies ethical complexity. Surgeons will assume roles outside their expertise, leaving elective patients with genuine needs waiting for surgery in a vacuum of temporal guarantees about rescheduling.

We need to recognise that these challenges are not trivial. The previously possible – even routine – is suddenly no longer possible – with far reaching impact on patient care, and surgeon safety[2]. There will be a difficult adjustment period; while some healthcare workers (HCW) might experience severe psychological or moral distress[3], every HCW will be discomforted during this time of emergency[4]. There will be concern about risk to self (and, by extension, to others) and the inherent limits of personal protective equipment – exacerbated by their relative lack of availability as the crisis unfolds. There may be occasions when staff are required to make personal choices about the level of risk to which they are prepared to be exposed. Those at higher risk may well be justified in stepping away from the front line earlier – but they can contribute in other ways. 'All being in this together' does not mean that we must all do the same thing - only that we should do what we can, when we can.

The pandemic will necessitate adaptation and innovation and, as surgeons well know, this brings its own ethical challenges[5]. The use of off-label drugs and conducting rapid clinical trials brings additional ethical challenges, which can nonetheless be rationalized[6]. Surgeons may be asked to redeploy into unfamiliar fields[7], raising difficult ethical questions: is it acceptable to refuse to move outside a specialty because of concerns about ability to perform? What if there is a risk to patient safety? What if there is no alternative? Should surgeons be prepared to step in, because even doing an imperfect job is better than doing nothing at all?

There is a professional obligation for the surgeon to use his/her training to support the healthcare effort. This means doing what one can, even if this means acquiring new skills and roles. Performing any technical procedure with insufficient training or experience may put patients at risk, so adherence to competency guidelines is important. That said, the ethical duty of rescue suggests that if you are the only person present who has a chance of being able to help – however insufficiently trained you may feel – it is acceptable (perhaps even obligatory) for you to do what you can. This is particularly so if failure to intervene would lead to imminent death: any effort is likely better than no effort at all. The UK Government recognises that questions of liability might later arise, so the Coronavirus Bill, currently racing through Parliament, seeks to provide indemnity, not only for those providing care to patients with Covid-19, but also to those providing care that they would not ordinarily[8].

Elective surgical patients whose procedures are delayed cannot be neglected. Mass postponement/cancellation is not without precedent[9], but the uncertainty about when procedures can and will be rescheduled is a new issue. Even when procedures must be postponed, patients deserve to know that they are not abandoned. As others have put it aptly, it might not be possible to treat everyone, but absence of treatment does not mean absence of care[10]. At a minimum, these patients deserve clear communication and an explanation about why procedures are being postponed. The immediate health needs presented by Covid-19 require prioritizing treatments that are urgent and lifesaving, which means that many people will have to live longer with ailments that impact on their quality of life (some very significantly) but do not threaten it. The ethical underpinnings of prioritization decisions vary, and each nation will have guidance to inform such decisions. Justification for the sort of prioritization depicted above could be framed as strictly utilitarian, aiming to maximize the number of lives saved. In this kind of calculation, the patient suffering endured as a result of postponed surgery counts for less than the lives that otherwise would be lost.

An alternative way to inform prioritization decisions, which may be preferable, involves thinking about how a just society would function at a time like this. The philosopher

Rawls[11] proposed a simple thought experiment. Imagine that we are behind a 'veil of ignorance', in which we do not know anything about ourselves. Behind the veil, we do not know whether we are young or old, rich or poor, healthy or sick, and we know nothing about our ethnicity, gender, or occupation. In this position of ignorance about ourselves, the decisions we would make about the just distribution of limited resources are more likely to be good and fair, because we are thinking beyond self-interest – instead focussing on what kind of world we are willing to live in, regardless of our place in it. We are more likely to make decisions that protect the most vulnerable in society, if only for the self-interested reason that it might be ourselves who prove to be the most vulnerable when the veil is lifted.

It is our feeling that, when asked to consider the situation from behind the veil of ignorance, most people would – and should – be willing to accept a healthcare system that, in times of extreme need, prioritizes urgent, life-saving measures and related efforts to save lives by tackling the pandemic. Similarly, the surgical community would – and should – be willing to accept a system that asks surgeons to re-direct their energies and work outside of their comfort zone. This willingness should be borne both from solidarity with the most vulnerable in society, and from a reasonable self-interest in having a system that will look after us, should we need it. The price we pay – and should pay willingly – for that safety net is to contribute to it when we can.

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The *BJS* team wish to reach out to express our support and gratitude to surgeons and healthcare workers around the globe. These are difficult times and your leadership is key to providing the best care possible. *BJS* welcomes submissions relating to the challenges faced in this pandemic (expect publication within a week). A blog has been launched (cuttingedgeblog.com) and publication of accepted pieces will be within hours.

Best wishes to you all.

Des Winter MD (Editor-in-Chief) on behalf of the *BJS* Editors, production team, Editorial Council and Board